MEDICAL READINESS STAFF FUNCTION

By
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The key to a successful medical readiness program is the level of effectiveness, commitment and leadership provided by the Medical Readiness Staff Function (MRSF) for active duty (AD) units or the Executive Management Committee (EMC) for Air Reserve Components (ARC) units. Our medical inspectors frequently encounter deficiencies in this critical area. This usually correlates to problems with other components of the unit's medical readiness program. With today's increasing focus on homeland defense, increasing mobility commitments throughout the world and newly acquired Unit Type Code (UTC) packages placing almost all medical personnel on "mobility," establishing and maintaining a strong oversight authority becomes even more critical to the unit's ability to respond to all possible medical contingencies. To assist the unit in improving the effectiveness of the oversight authority, we would like to review some of the requirements and our observations regarding an effective MRSF/EMC.

Let us start with the composition of the oversight authority. AFI 41-106, Medical Readiness Training, requires that the MTF or unit commander chair the committee. That means that the commander attends, participates and signs the minutes–not the deputy commander or the administrator. Other members should include unit staff members that either make decisions or affect the unit's medical readiness program through maintaining, training, exercising or advising the committee. Therefore, your short list of attendees should include: the unit commander; the executive management team; medical readiness officer (MRO)/NCO/manager; Nuclear, Biological, Chemical (NBC) medical defense officer/NCO; NBC casualty management officer; director/chief of medical logistics; medical intelligence officer (MIO); exercise evaluation team (EET) chief; ARC liaison (if appointed); and any others selected by the commander. *We recommend* including the self-aid/buddy care monitor and the unit training manager. For ARC units, members of the EMC serve as the oversight authority and medical readiness issues are incorporated as standard agenda items for the EMC. The frequency of oversight review is now quarterly for both AD and ARC units.

MRSF/EMC minutes documenting discussions of medical readiness issues provide inspectors with an important gauge for assessing the effectiveness of the oversight authority. Meeting minutes should provide a clear, concise summary of discussions and events. This area is typically deficient for many units. At times the format of the minutes (e.g. a spreadsheet format) may lead to minimal or insufficient discussion of events. No matter what format you choose when preparing your minutes, *we recommend* that you ask yourself the following questions:

- Have I captured what's important to others who might be reading the minutes? You don't need a blow-by-blow listing of differing opinions, but a short summary to include a consensus of the group and an indication of issues left to be resolved is helpful.

- Did I indicate accurately whether the issue is closed or opened? Don't be in a hurry to close items if not properly researched for the best solution, and don't leave them open for extended periods of time hoping for a policy change. Remember, open items from exercises MUST be tracked until resolved and tested before closure can occur.
- Did I assign an office of primary responsibility (OPR) and an estimated closure date? If the OPR is always the MRO/NCO/manager, then you're likely to be overwhelmed just managing the minutes. Seek the oversight authority's support in assigning the appropriate OPRs.

In short, your minutes should provide sufficient information to serve as a historical record of issues encountered and resolved. Think how frustrating it would be to attempt procedures that have already been determined to be unfeasible; yet, those less-than-effective alternatives were never documented in previous minutes. Consider future impact when preparing your minutes.

The oversight authority should review items during the meeting that reflect the status of the unit's preparedness. When building your standard agenda items, consider all of the important measurements and/or reports that you have available to present. Although there is no one perfect agenda, AFI 41-106 offers some guidelines.

- Status of Resources and Training (SORTS)/AEF Reporting Tool (ART)/Medical Readiness Decision Support System (MRDSS): This doesn't need to be a classified briefing. You can report UTC manning, training, and War Reserve Materiel (WRM) status without their associated SORTS C-ratings or ART color ratings. Ensure training status covers all SORTS measurable training as outlined in AFI 41-106, para 5.4.1. Most units accomplish the majority of training requirements during formal courses or the unit's field training. The minimum UTC training includes a review of the UTC's concept of operations and allowance standard. If the unit possesses a corresponding equipment assemblages, this much be exercised every AEF cycle to consider the UTC fully trained for SORTS. (For HSI inspections, be prepared to show documentation to support completion of this training). Ensure your MRDSS includes a status of RAPID and in-place Patient Decontamination Capability packages, if applicable. AFRC units will interface with MRDSS through the Web Based Integrated Training System (WBITS2). Address the date(s) the data in these three systems was updated, and if any errors were found that need(ed) correcting. This is particularly important for SORTS and ART data, as errors in these systems often require new reports.
- Training and exercise schedule updates: This update should parallel your annual master medical unit readiness training (MURT) and exercise plan. Prior to the next calendar year, you must present, obtain approval, and attach your annual MURT and exercise plan to the minutes. The master MURT/exercise plan should cover all items outlined in AFI 41-106, para 1.7.10.
- Deployment After Action Reports: These are different than post exercise/incident summaries. Medical treatment facilities and units, including ARC, must complete

after-action reports after support of a contingency operation or participation in a higher headquarters exercise (AFI 41-106, para 6.9.1).

- Results of inspections: Brief findings from staff assistance visits, operational readiness inspections, health services inspections or self-inspections. Ensure open items have corrective action plans and are tracked until closure.
- Postexercise or incident summaries: *We recommend* having the appointed EET team chief brief exercise results rather than the MRO. Include a review of all open items. Do not close items until corrective actions have been implemented or equipment/training received AND you have tested the success of your solution. Unit commanders should elevate corrective actions that go beyond unit capabilities. Summaries must be attached to the minutes and not just discussed.
- Status of Medical Unit Readiness Training: You must include status of training for core, deployment, field and just-in-time readiness training requirements. *We recommend* you develop a reporting tool based on Attachment 3 of AFI 41-106 for ease of review. You may want to include SABC (if not covered under core items, Wound Care and Casualty Mgt) and combat arms training.
- AFSC-specific training: *We recommend* that AFSC functional training managers take turns briefing the status of their training, perhaps alternating meetings, to allow each AFSC to be updated. In addition to providing an update, you must provide the MRSF with a written report of skills that cannot be accomplished at unit level. The report will include reasons this training cannot be accomplished. Although the frequency of the report is not specified in AFI 41-106, *we recommend* at least an annual review.
- Plans/Support Agreement Review: Review base support plans and MOU/MOAs annually to ensure any changes in the unit's mission or medical resource capability are reflected in the plans and MOU/MOAs. You must rewrite the MCRP (not applicable to the ARC units) every 3 years or when 35% of more of the document changes. The Emergency Management Plan (ANG) is rewritten based on state requirements. Ensure that the MIO and NBC MDO review plans/MOU/MOAs to assess threats and ensure appropriate clinical responses.
- Team training status: *We recommend* that disaster team chiefs brief the status of their team training (UTC training is reported with SORTS/ART/MRDSS). Some units report only that team training occurred. However, status implies an assessment of current training in comparison with overall training requirements. *We recommend* you calculate a percentage trained and include any issues related to accomplishment of make-up training.
- Deployed resources: The AFI specifically addresses deployed personnel, but maintaining visibility over deployed WRM equipment packages may be useful if only for coherent record keeping. This information may also be briefed as part of the SORTS/ART/MRDSS update, since deployed resources must be identified in these reports.
- Medical Intelligence Officer briefing: This area is not applicable to AE. The MIO briefing must include those items outlined in AFI 41-106 para 1.8.6.
- Additional MAJCOM items: As specified by your MAJCOM.

Active duty units must send a copy of their minutes to the MAJCOM/SGX for review.

We hope these suggestions will help you build a clear, concise historical record for your unit's readiness program. If you have any questions, please contact Lt Col Danita McAllister, DSN 246-2491 or SMS Fred Lopez, DSN 246-2474.